## Indiana Family and Social Services Administration Division of Mental Health and Addiction

Consultative Clinical and Therapeutic Services Provider Certification- Agency Form

Name	of Agency:	Date:
Name	of person completing form:	
Email/	Phone Number of person completing form:	
All age	ncies must attach copy of at least one of the following:	
	Certification by the Division of Mental Health and Addiction (Health Center	DMHA) as a Community Mental
	Approved accreditation by a nationally recognized accreditin ACAC, JCAHO, OR NCQA	g body: AAAHC, COA, URAC, CARF
	Articles of Incorporation	
are exp	submit this form and copies of required documentation to the pected to maintain documentation of employee's qualification DMHA staff complete audits.	<u> </u>
	is responsible for verifying an agency meets the above qualific or accreditation.	cations initially and at renewal of
	cies without an approved accreditation must complete the ind	ividual form and submit to DMHA

## Indiana Family and Social Services Administration Division of Mental Health and Addiction

Consultative Clinical and Therapeutic Services Provider Certification- Individual Form

Name:	Date:		
Please attach the following documentation:			
	Copy of picture identification card (Picture of person on card must be recognizable.)		
	Copy of Licensure: HSPP as defined in IC 25-33-1; Licensure Marriage and Family Therapist; Clinical Social Worker; or Mental Health Counselor under IC 25-23.6		
	Certification from training on System of Care values and philosophy		
	Certification from training on Participation on Child and Family Teams		
	Certification from DMHA Waiver Provider Training		

Please submit this form and copies of required documentation to the CA-PRTF Team at DMHA. DMHA is responsible for verifying an individual meets the above qualifications initially and at renewal of license or accreditation.